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Developing a Health Care System in Ghana*

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Many investigators, interested in health problems, have discovered that whether or not a person gets sick, the kinds of disease he acquires, and the kinds of treatment he receives, depend upon social, cultural and psychological as well as biological factors.[1-5] This discovery led to the realization that medical care of patients can be improved by utilization of psychological, social and cultural knowledge along with the generally available biological skills. This approach to medical care involves essentially a changing conception of disease and the strategies for dealing with it. Weinerman[6] argued, that the western model of disease and its causation requires a serious modification in the face of the socio-environmental pressure. He maintained that a patient's cultural environment produces a variety of manifestations that interfere with life functions. What this implies is that medicine now requires a conception of health and illness which takes into account socio-cultural orientations of the people it serves. Medical science, therefore, transcends the realm of the biological.

In providing effective health care in the West African societies, the problem is not merely the availability of health resources such as personnel, drugs, and financing by the local governments of these developing countries where traditional and scientific medical systems co-exist. The problem, however, is how to integrate scientific health resources with the indigenous culture and social structure. There is the need for health care practice in these societies to extend its areas of interests to include all participants and elements contributing to "healthful" life. Such a perspective requires a concept of health care that recognizes all etiological factors mentioned above.

This paper argues for the consideration of traditional medicine in the overall planning of health care in the developing West African societies. All activities surrounding health care in these societies will be discussed. Health is defined as "a state of complete physical, mental and social well-being, not merely the absence of disease and infir-

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mity''[7] Therefore, the position taken is that health care is a product of an interaction process between a variety of institutions. This concept of health care is based on the premise that health care ''emerges as a composite beyond the exclusive control of one system and that it is the product of a negotiated system of interaction which yields accommodative consequences between ideologies, systems, roles and tasks''.[8]

This perspective on health care seeks to call for a change from scientific dominated health care delivery system in West African societies to a network of shared responsibilities in which traditional medicine also becomes a functionary in the provision of legally approved health services. As a result of contemporary social changes, there is the need to develop a medical model which will articulate with the medical needs of the recipient society. This has implications for other developing countries or economies in which there is the co-existence of two medical systems. In terms of viable utilizations of medical models, the institution of medicine must take into account the total world-view of the people, the prevailing social norms, the stage of economic growth, the choice factors, and the value orientation.

CLARIFICATION OF BASIC CONCEPTS

Medical systems have broad ranging ties with the way of life of a people. The institution of medicine has ties with philosophy, religion and the entire belief systems. As an institution, it is a cultural universal. All societies have developed institutions of medicine to deal with the problem of risk and uncertainties of illness, both philosophically and pragmatically.

In Ghana, two medical systems exist contemporaneously. The individual is the double beneficiary of both. These systems exist in a mutually independent context with little prospect of one displacing the other. But the apparent contradictions that emerge between local medicine and its related laws and the scientific medical institutions, tend to pose problems for both the users and for the practitioners.

We need to clarify the use of the terminologies, traditional and scientific medicine. Traditional medicine is a generic concept which embraces many practitioners of herbal medicine, the fetish priests, priestessess and spiritual healers of various categories. The essential factor in the practice of traditional medicine is the constant utilization of magico-religious acts and concepts. This is not to argue that practitioners of traditional medicine have no notion of physical cures and treatment. Many of them have a stock of specific remedies to treat ills. Some have been tested to have scientific validity. Wounds are bandaged and broken bones are set and bound. Stimulants and sedatives are common phenomena in the traditional medicine man's pharmacopeia. However, most treatments are regarded as aspects of a total treatment which does include magico-religious ingredients.

When one looks at traditional medicine, the explanation for many illnesses is found in some anti-social behavior on the part, either, of the victim or of some persons closely related to him in the extended family network. Viewed in this light, the diagnosis of illness is regarded as diagnosis of a social offense, and the curing of illness requires the righting of some social wrong. What is important is not the form the medicine man employes, but, the place medicine occupies in the life of people, the spirit which pervades the practice and the way the underlying traditional medical theory merges with other traits of traditional cultural experience.

In the contemporary West African societies, traditional beliefs about health and illness are still prevalent. Thus, in considering the individual's health behavior, one realizes that the individual manifests a deep sense of order and perception in his relationships with others in both human and spiritual worlds. The individual tends to find security in the hidden forces of the ancestral and other spirit agents. He is aware of his dependence on the other members of the group and upon these spirit entities. He comes to believe that deviations and disobedience at personal and social levels may bring penalties from the spiritual world and that illness and health are

some of the inevitable consequences of such deviant behavior. The quest for life and well-being has created the desire to search for and come to terms with other forces in the individual's environment.

The traditional medical practitioners often utilize the cosmological ideas about the individual, his relationships with ancestors, gods and his fellow man in order to establish a total context of illness which they must modify if the patient is to get well. As they carefully read the super-natural revelations during diagnoses, they also probe assiduously the patient's life history. The practitioner who diagnoses the intervention of a spirit or god as the cause of illness also diagnoses what moved the spirit or god into action. He usually discovers that human hatreds, jealousies and misdeeds have brought these spiritual beings into action. Etiology of illness and the concept of health are far more behavioral than biological. It follows that traditional medical theory has no purely naturalistic idea of illness since there is no clearcut conceptual separation between the physical and the supernatural worlds.[9-11]

In general, traditional medicine has a recognition of social, cultural and psychodynamic factors in the etiology of illness, and the importance of interpersonal relationships in therapy. Some aspects of the practice are oriented toward a religio-moral ideology, and deal directly with anxieties and guilt associated with social living. Traditional medicine tends to deal with effects of interpersonal relations in the therapeutic process and mobilizes the cultural resources of the community to give aid to the sick. For example, in Ghana, gods, ancestors and fetishes, who are believed to make the land yield and who watch over the human families and cattle and bring peace and prosperity, expect and demand good will and moral rectitude from men. Any individual in the community who would think evil of other men or commit any misdemeanor would be "caught by the fetish" and would become sick. If he confesses quickly and is cleansed, he recovers. If he refuses to confess he dies of the "fetish caught." Cannon[12] observed a similar process of dying in the voodoo death where the victim is left to wither away to death. The point here is that the guilty conscience and the rancorous thought of the offender are likely to result in psychosomatic ailments. Treatment usually consists of a confession followed by performance of propitiatory ceremonies to avert any further misfortunes. The practitioner may also order the victim to give a feast and invite his friends in order to rectify the strained social relations and clear the offender's rancorous thoughts. In dealing with illness, the traditional medical practitioner fulfills other functions besides the prescription of herbs. He tells the causes of illness—not necessarily in bacteriological terms—but more fundamentally why a particular person at a particular time fell victim to disease or any other misfortune. He also mobilizes the social solidarity resources of the victim's environment to initiate a therapeutic process which is itself social in nature. Traditional medical theory views disease in the light of social causation. In this context, the medicine man performs what Turner[13] termed, "social analysis."

On the other hand scientific medicine utilizes scientific methodology. It means the rational explanation of natural events is seen in terms of specific empirical cause and effect categories; causation is viewed as natural in contrast to supernatural assumptions. According to the scientific process of inquiry, facts in the system of belief are arrived at by observation of data. By description and categorization of phenomena, analytical classificatory systems are derived. The process of induction is used to derive and/or formulate hypotheses. From these deductions, predictions are made about relationships between events. These ideas are verified and/or dismissed through further process of inquiry and experimentation. It is the premise of scientific methodology, the *sine qua non* of scientific medicine, that the results of new experimentation can change the basic paradigms and principles. Natural causes are sought to allow in all cases for change when demanded by new evidence. On the basis of specific empirical evidence, therapeutic measures are then rendered (to be rectified in the face of new facts).

The Society. The West African societies can be described as traditional (using Max Weber's concept of the term). The norms are enshrined in traditional cosmological pattern. The best way to act is the way the ancestors have ordained. That which is legitimate is enshrined in the past. In the traditional belief system, serious illness of any sort is thought to be caused by the ill will of another person, god or an evil spirit which has wormed its way into the social group. In Ghana, the vast majority of the people (about 71%) act according to this traditional way of life. And it is difficult to estimate how far those in the urban areas are removed from this traditional cosmological pattern. Furthermore, the scientific medical institutions are mainly located in the urban areas and central towns of Ghana. It is estimated that about 29% of the Ghangian population live in urban areas. The vast majority of the Ghanaians live in rural and other outlying places.

Contrast Between the Two Systems. From the ongoing discussions it should be clear that one commonly accepted way of contrasting traditional medical thought with scientific thought is misleading. One is thinking of the contrast between traditional thinking about medicine as non-empirical and scientific thought as empirical. The contrast is misleading in the first place because traditional medical theory is no more nor less interested in the natural causes of things than is the theoretical paradigm of the sciences. Indeed, the intellectual function of its supernatural being is the extension of people's vision of natural causes. In the second place the contrast is misleading because traditional medical theory does more than postulate causal connections that bear no relation to experience. If some of the connections it postulates are almost certainly real ones, then it grasps reality as it is defined in the traditional social setting. It is not claimed here that traditional thought is a variety of scientific thought but in certain crucial respects, the two kinds of thought are related to experience in quite different ways.

We may raise two questions, what occasions do people ignore the spirit world, and what occasions do they attend to it? Radcliffe-Brown and others after him, claim that people think in terms of the spirit world when they are confronted with the bizarre, the unusual or the uncanny. They think this way in the face of anxiety provoking situations or they think along these lines whenever they are faced with any of the emotionally charged situations. It is hard to make a clear cut distinction between objective and subjective ways of thought. Hsu[14] claims that even in the science oriented settings men do not always think along "scientific" lines. The Weberian thought on this point is that the non-rational elements are essential in motivating people to action. Weber was not merely interested with the phenomenological description of these elements; rather he placed the non-rational elements within the context of general theory of action[15].

The dominant Ghangian government value orientation emphasizes scientific medicine, its attitude toward rationality and empiricism. It puts a certain pressure on people adhering to traditional beliefs and practices. Except within isolated reference groups, the general opinion is likely to devalue traditional practices in the realm of acute ills (wounds of all natures, infectious diseases and diseases of specific causation). It would seem reasonable to infer that it would be difficult for such people (with acute ills) to escape the feeling that traditional practices *vis a vis* acute ills are not quite up to the times. This leads us to expect a certain type of conflict within people who have a positive orientation towards traditional medical orientation. It is also worth noting that people can maintain parallel set of orientations. Utilizing a sample from four communities, Nukunya and Twumasi found this to be the case. The functional scope of each system is largely determined by its ability to get results.

In keeping with man's pragmatic spirit characteristic of so many facets of life, the sick person would show a willingness to take what each medical system has to offer, to the degree that its usage appears to yield favourable results. The sick person's evaluation of the systems are fixed upon effects.

Towards Convergence Model. Scientific medicine, we have argued, is built upon

questioning and change; traditional medicine is built upon tradition and certainty. There is little doubt that in the social-psychological sphere the reassuring effect of the latter attitude is the greater one. Employing the scientific method, scientific medicine proceeds in an analytic way, in splitting phenomena into smaller units with the aid of scientific categories. Traditional medicine on the other hand, ties together as many phenomena as possible. It aims at, and obtains to a certain degree, a maximum of mental integration. It has a holistic character when compared to scientific medicine. To the medicine man, there is no conceptual separation between physical and mental disease, there is only disease. There is no separation between diagnostics and therapeutics.

Disease is fundamentally a disintegration on all levels, mental, physical, and social. It is understandable that the therapeutic approach of traditional medicine should have some value. There is a need to broaden the scope of scientific medical theory in its present form to incorporate the social, the psychological, and the physical aspects of illness. But the scientific medical practitioners operate within a well-built ideological base. They have built a wall around the practice and for that matter have a firm base in the bargaining process. They live in a community within a community, and tend to make it difficult for the recognition of traditional medical practitioners. Operating with the economic theory of demand and supply, there is the fear that if traditional practices are legitimized by the government, there will be depreciation in the value orientation of scientific medical practice. But the important thing to do is to consider the functional scope of each medical system. The traditional healers can throw light on psychotherapy. They utilize the language of the people and other cultural symbols in treatment since they share the same frame of reference with their patients. The scientific medical doctors have their technology, operating as technicians, and have developed what sociologists call "trained-incapacity" in dealing with certain health problems especially those that are related to the psychodynamics of individual patients. The two can integrate in order to utilize each effectively.

The success of the convergence will depend on how certain critical problems are solved. First, there is the need for health care planners to deal with the difficulty of getting some doctors to function as colleagues with traditional healers.

Secondly, it is necessary for all health workers to accept that to deal with the complex health problems requires contributions from many areas, and that all health workers must be able to jointly assess what resources can best be utilized for diagnosis, treatment and health maintenance of the patients.

Thirdly, there should be recognition that certain variables tend to influence the sick person in his attempt to repair the damage: rural-urban living, belief orientation, the availability of a medical clinic, the nature and type of disease and the awareness of relevant medical technology, and that the process of making a choice involves a subjective process of orientation to an objective situation. His action should be conceived as a process directed towards the realization of goals or toward the expression of values. The inclination is that the individual uses his very limited powers of prediction and control in an attempt to bring some small portion of the future into harmony with his ends and values. The action he takes implies an effort directed towards the overcoming of obstacles. Implicit in the process of decision making is the problem of economizing and counting the cost of the projected line of action in terms of the sacrifices the course one takes entails for other values he holds important. The sick person takes each system to suit what he thinks will minimize the risk and uncertainty. Twumasi pointed out that increased numbers of pregnant women from both rural and urban settings now utilized modern medical services for consultation and delivery purposes[10]. This increase in the use of modern medical services is due in part to the demonstration effect and to the conviction that modern medicine is efficacious in alleviating acute situations, and in terms of availability model. These acute illnesses have come to be seen as "ordinary" illnesses

which readily respond within a few days to antibiotics. If, however, victims do not recover fairly quickly, the illness is considered not natural. In such circumstances, an illness may be reconsidered and redefined as "unnatural" and outside the domain of modern medicine. As such, its treatment requires the attention of a traditional medical specialist. Traditional medicine then tends to represent a stage of illness behavior or an alternative to scientific medicine.

Fourthly, there is the need to develop a health care delivery system that reflects the needs and expectations and values of the patients. In this regard communication difficulties between doctors, traditional healers and patients should be overcome to provide information flow and record keeping so that decisions are made by those with the best knowledge and information and who are closest to the problem.

Fifthly, it may be necessary to train the healers in hygiene and documentation of medical records, and it would be ideal to start to recruit more literate people in the traditional medical practice. In a study of current trends in the traditional healing in Ghana[16], it was found that all healers were willing to learn about simple clinical procedures and hygiene, and were willing to refer their patients to the hospitals. About 83.3% of the healers in the sample referred their patients to hospitals and doctors for specific or further treatment. The study also revealed that the analysis of widely used traditional herbs is a major concern of the Institute of Scientific Research into Plant Medicine in Ghana. This institute is encouraging research and teaching of various processes for obtaining the medical virtues of plants. The research is also intended to aid a compilation of materia medica on African medical botany. Continuous efforts by traditional healers to encourage the study of medical herbs have in recent years attracted the attention of local universities and specialized research organizations such as the Ghana Academy of Sciences. These institutions of higher learning and research are now inviting cooperation and participation in the acquisition and documentation of knowledge on herbs and how these herbs can be scientifically stored. The Pharmacology Department of Kumasi University of Science and Technology, for example, and the Department of Botany at the University of Ghana are currently sponsoring programs to study the medical properties of West African herbs and the manufacture of pills, syrups, and other drugs.

CONCLUSION

Patients seek effective treatment. But except in straightforward short illnesses, they also want more. They seek explanation, reassurance, personal interest and help in coping with other problems associated with their illness. When these are not obtained, the treatment which would be effective would be rejected. Studies done with respect to health and illness behavior indicate that absconders or defaulters who leave the hospital to go to other non-scientific healers are not only grasping last straws, but are advocating a wider and integrated concept of a health care system. In the developing West African societies, it will be many years before enough facilities in both medical and psychiatric services of the western type are provided. In the face of this inadequacy in facilities, the people would benefit from incorporating the traditional health care system into the general health delivery system. Medical services can be improved by utilization of traditional medicine along with the generally available scientific medical skills. It may be argued that scientific medicine in these developing societies is introducing the "irrelevant", the "mystical", and the "incompetent" into orthodox medicine, but it is important to consider what is operationally and functionally effective in the African cultural experience.

LITERATURE CITED

1. ACKERKNECHT, E. H. Primitive Medicine and Cultural Patterns. Bullet. Hist. Med, 12: 545-574, 1942.
2. KOOS, E. L. The Health of Regionville: What the People Thought and Did About It, New York: Columbia University Press, 1954.

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of Budapest which celebrated its 200th anniversary in 1969. There were 10,590 physicians in Hungary in 1938 and 24,900 in 1973. The use of medical auxiliaries has trebled during this period.

Hungary has a population of 10 million. Its 24,900 physicians are in short supply. All work for the government at a starting salary of about $100 per month. The four medical universities of Budapest, Pecs, Debrecen and Szeged graduate 1000 doctors a year after six years of medical training. After five years of government service they are eligible to attend a fifth medical university which is a post-graduate school for specialty training, called the Institute for Post-Graduate Training of Doctors that offers training in 34 specialities. Ninety-five per cent of the students receive grants for subsistence and medical education is free. Sixty per cent of medical students are females.

Although 97% of the population is socially insured and drugs are free, many patients prefer to choose their own physician on a fee-for-service basis. Many seek another opinion or wish to confirm one. Others seek to escape the overcrowded clinics for service on a more personal and unhurried basis. Many physicians discourage this practice since they must pay high income taxes on private earnings.[5]

The labor code of Hungary permits and expects health workers to join their trade union. In addition to improvement of living and working conditions, it encourages continuing education and attendance at annual conferences, has developed a 250,000 volume library, promotes social, cultural and recreational consciousness, and maintains low-fee holiday, nursing and pensioners homes.

There are 605 local trade union chapters. Some 95% of health workers are members. Membership dues are about 1% of the member's income. It is interesting to note that 53% of the membership dues are devoted to social expenses, 29% to culture and sports, and 18% to organization and administrative work.

LITERATURE CITED

1. Twenty-five Years of Public Health in Hungary. Ministry of Public Health. Medicina Publishing House. Budapest, 1970.
2. JELLINEK, H. Personal communication, August 24, 1973.
3. STREICHNER, R. Personal communication, August 23, 1973.
4. MESTER, E. Personal communication, August 23, 1973.
5. Patients Prefer Private Practice. International Comments. J.A.M.A., 227: 950-951, 1974.

(Twumasi & Bonsi, from page 344)

3. MAC BRYDE, C. M. Signs and Symptoms, Philadelphia: Lippincott, 1964, p. 1.
4. COE, R. M. and A. F. WESSEN. Social-Psychological Factors Influencing the Use of Community Health Resources. Amer. Jour. Pub. Health, 55:1024-1031, 1965.
5. SUCHMAN, E. Sociomedical Variations Among Ethnic Groups. Amer. Jour. Sociol., 70:319-331, 1964.
6. WEINERMAN, E. R. Anchor Points Underlying the Planning for Tomorrow's Health Care, Bull. New York Acad. Med. 41:1213-1226, 1965.
7. COE, R. M. Sociology of Medicine. New York: McGraw-Hill, 1970, p. 13.
8. MAUKSCH, H. O. Nursing: Churning for Change?, University of Missouri, Columbia. See also Handbook of Medical Sociology. 2nd edition, Howard E. Freeman, Sol Levine and Leo F. Reeder, eds. Englewood Cliffs, New Jersey: Prentice Hall, 1972.
9. MBITI, J. S. African Religions and Philosophy. London: Heinemann Educational Books Limited, 1970.
10. TWUMASI, P. A. Ashanti Traditional Medicine. Transition, V 2:50-63, 1972.
11. MIDDLETON, J. Magic, Witchcraft, and Curing. New York: Doubleday Anchor Books, 1954.
12. CANNON, W. B. The Voodoo Death. Amer. Anthropol. 44:169-181, 1942.
13. TURNER, V. The Ritual Process. Chicago: Aldine Publishing Company, 1969.
14. HSU, F. L. K. Religion, Science and Human Crises. London: Routledge and Kegan Paul, 1952.
15. WEBER, M. The Theory of Social and Economic Organization. New York: Free Press, 1952, pp. 18-27.
16. BONSI, S. K. Traditional Medical Practice in Modern Ghana. Unpublished Ph.D. dissertation, Columbia: University of Missouri, 1973, pp. 144-157.